Spending for the HI program would be reduced primarily because payment rates to providers would be lower than under current law. Specific provisions of the proposal would:

- Reduce the updates to the per-case rates used by Medicare's prospective payment system (PPS), which pays for inpatient hospital services, for fiscal years 1997 through 2000;
- Eliminate the adjustment to PPS payments for the indirect costs of patient care that are related to hospitals' medical education programs--although a portion of the amount that would have been paid under this adjustment would be transferred to the fund for academic health centers;
- Reduce the base payment rates for capital-related costs of inpatient hospital services and reduce the updates applied to those payment rates for fiscal years 1996 through 2003;
- In states that were participating in the proposed new health care system, revise and, on average, reduce the PPS payment adjustment for hospitals that treat a disproportionately large share of low-income patients; and
- Reduce the updates to some payment rates for skilled nursing facilities in fiscal year 1996.

The largest reductions in spending for the SMI program compared with current law would result from lower payments for physicians. The specific provisions would:

- Establish goals for cumulative expenditures for physicians' services. Currently, the target rate of growth for each year is based on the prior year's actual rate of growth in outlays for physicians' services, without regard to the prior year's target rate of growth. Under this proposal, the growth target for outlays for physicians' services would be built on a designated base-year target (fiscal year 1994) and updated annually for changes in enrollment and inflation but not for actual growth in outlays above or below the targets for prior years.
- Institute a new system for setting the target rate of growth for payments to physicians. The new system would both substitute the average rate of growth in real gross domestic product (GDP) per capita (plus 1.5 percentage points for primary care services only) for a measure of the change in the volume and intensity of services provided by physicians during the previous five years, and eliminate the annual percentage reduction known as the performance standard factor.
- Eliminate the floor on the reduction permitted in the default update for physicians' payment rates. Currently, there is no upper limit on increases in physicians' fees under the default update formula, but fees cannot decrease by more than 5 percentage points.
- Reduce the conversion factor for the fee schedule for services (except for primary care) provided by physicians by 3 percent in 1995. The conversion factor is a dollar amount that converts the fee schedule's relative value units into payment amounts.
- Limit payments for physicians' services provided by medical staffs at high-cost hospitals, effective January 1, 1998. This proposal would establish limits on Medicare's payments for physicians' services per inpatient hospital admission, similar to limits on payments for hospital services.
- Limit total payments for certain outpatient hospital services to Medicare's approved amounts, effective July 1, 1994. Medicare enrollees' coinsurance liabilities for hospitals' outpatient services are now based on the hospitals' actual charges rather than on Medicare's (typically lower) approved amount for the services. Because Medicare usually pays 80 percent of the approved amount, hospitals often receive more than the total approved amount. This provision would reduce Medicare's payments for hospitals' outpatient services by the amount of patients' extra payments for coinsurance.

- Require Medicare beneficiaries to pay 20 percent coinsurance for all laboratory services, effective January 1, 1995. Medicare currently does not require copayments for clinical laboratory services, although most other SMI services are subject to a 20 percent coinsurance requirement.

- Establish a competitive acquisition process for magnetic resonance imaging tests, computerized axial tomography scans, oxygen and oxygen equipment, laboratory services, and other items at the discretion of the Secretary of HHS, effective January 1, 1995. If competitive bidding did not reduce average prices for those services by at least 10 percent, the Secretary would reduce Medicare's approved fees for those services to accomplish the same goal.

The provisions that would affect both Hospital Insurance and Supplementary Medical Insurance are quite diverse. They would:

- Retain Medicare's role as a secondary payer for disabled employees and employees with end-stage renal disease (who would be insured through their firms). Under current law, Medicare would become the primary payer for those enrollees as of 1999.

- Establish new standards for Medicare's payments to HMOs and competitive medical plans with risk-sharing contracts. Currently, Medicare pays 95 percent of the average adjusted per capita cost (AAPCC) for Medicare enrollees in each county. The program would establish a range around the HI and SMI components of the AAPCC, varying from 80 percent of the national average value up to 150 percent for SMI services and 170 percent for HI services. The intent would be to encourage more HMOs to participate in Medicare while establishing reasonable limits on reimbursement in counties whose AAPCC is high.

- Reduce the limits on payments for routine costs for home health services. In past years, Medicare's payments for home health services were limited to no more than 112 percent of average home health costs nationwide. This provision would reduce the limit to 100 percent of median costs nationwide.

- Require beneficiaries to make a copayment of 10 percent of the average costs for home health visits, excluding visits that occurred within 30 days of discharge from a hospital. Currently, Medicare requires no copayment for home health visits.

- Require the Secretary of HHS to contract with "centers of excellence" for the provision of cataract and coronary by-pass surgery and other services to Medicare beneficiaries, thereby expanding current demonstration projects to all urban areas. Medicare would contract with individual centers using a flat payment rate for all services associated with the affected surgical procedures. Patients would be encouraged to use the centers through rebates equal to 10 percent of the government's savings from the centers.

Reductions in the Medicaid Program

The cost of the Medicaid program would be substantially less than under current law. The proposal would terminate coverage for adult beneficiaries who did not also receive cash welfare benefits and would limit the rate of growth of the per capita payments to regional alliances for beneficiaries who did receive cash benefits, as discussed above. In addition, the proposal would end Medicaid's payments to disproportionate share hospitals--those that treat a relatively high proportion of low-income and uninsured patients--when the state began participating in the new system.

Issues of Governance

The Administration's proposal would place new responsibilities on the federal and state governments, create a variety of new institutions, and specify a complex flow of resources among those institutions.

The Role of the Federal Government

The federal government would play the major role in designing and financing the proposed health care system. Many of its functions would be the responsibility of a newly created National Health Board; other important responsibilities would fall to the Department of Health and Human Services and the Department of Labor.

Functions of the National Health Board. The National Health Board would have the mandate to:

- Interpret the standard benefit package;
- Oversee the cost containment provisions for regional alliances and certify that those requirements were met;
- Develop and implement eligibility rules relating to the coverage of certain individuals and families;
- Develop and implement standards for a national health information system for measuring the quality of health care;
- Establish and assume responsibility for a system to manage and improve the quality of care;
- Develop the multiplicative factors for converting premium amounts for individuals into premiums for couples, single-parent families, and two-parent families;
- Develop methods for adjusting premium payments to health plans so that the premiums reflected the health risks of their enrollees;
- Facilitate the development of a system of reinsurance so that plans could protect themselves against the financial consequences of enrolling a disproportionately large number of people with expensive medical conditions;
- Develop capital standards for health plans that contract with regional alliances;
- Develop standards for state guaranty funds, which would be used to pay providers in the event that a health plan offered by a regional alliance failed;
- Establish criteria that states must meet to begin participating in the system and monitor their compliance; and
- Review documents submitted by the states describing their proposed health care systems and approve or disapprove them.

Federal Initiatives to Ensure Compliance by States. The federal government would not only establish most of the criteria that states and alliances would have to meet but would also have to ensure that states met those standards. To that end, federal planning grants would be available to assist states in setting up their health care systems. The National Health Board, moreover, would have considerable authority to impose sanctions if necessary to enforce the standards. If it determined that a state's noncompliance resulted from the actions of a particular regional alliance, the board could order that alliance to comply and take additional measures to assure that it did so. The board could also require the Secretary of Health and Human Services to reduce federal payments to states for items such as academic health centers and health services research as a sanction for noncompliance. If, however, the board determined that a state was sufficiently far out of compliance that people's access to health services would be seriously jeopardized, the Department of Health and Human Services would take over the operation of that state's system. (The federal government would impose a 15 percent surcharge on total premiums in those circumstances.)

Oversight of Regional and Corporate Alliances. The Department of Health and Human Services would oversee the financial management of the regional alliances. Accordingly, the department would develop standards and conduct periodic audits relating to the alliances' enrollment of eligible individuals, their management of subsidies for premiums and cost-sharing amounts, and their overall financial management.

The Department of Labor would assume major responsibility for oversight of corporate alliances and employers in regional alliances. In particular, it

would ensure that employers in regional alliances paid their share of premiums, withheld and paid their employees' family share of premiums, and submitted timely reports. The department would also temporarily take over any insolvent self-insured corporate alliances; for that purpose, it would establish an insolvency fund to which self-insured corporate alliances would be required to contribute when funds were needed.

Federal Payments. The U.S. Treasury would make payments for several purposes. In particular, the government would be the main source of subsidies for low-income families, employers, and retirees. It would also finance a package of wraparound benefits for low-income children who were previously eligible for Medicaid, as well as pay the federal share of the restructured Medicaid program. In addition, funding would be required for program expansions such as Medicare's coverage of prescription drugs and initiatives such as home- and community-based services for severely disabled people.

The Role of State Governments and Alliances

Although the structure and standards for the proposed health care system would come largely from the federal government, the states and alliances would have the major responsibility for the day-to-day operation of the system. States would also have to help finance the new system.

Responsibilities of State Governments. Each participating state would be required to:

- Submit a document to the National Health Board describing the health care system the state proposed to establish;
- Establish one or more regional alliances, designating the geographic area that each alliance would cover;
- Ensure that families in each regional alliance had a choice of plans in which to enroll;
- Ensure that families were credited with any subsidies for their premiums to which they were entitled;
- Establish capital standards for health plans that met the federal requirements;
- Establish standards for financial reporting, auditing, and reserves of health plans;
- Establish the standards for certifying the health plans that regional alliances would offer, including criteria for quality, financial stability, and capacity to deliver the standard benefit package, and certify the plans to be offered;
- Establish a guaranty fund to pay claims and other debts in the event that a plan failed and, after a failure, collect an assessment of up to 2 percent on premiums to repay the obligations of the plan;
- Ensure continuity of coverage for enrollees in health plans that failed;
- Ensure that the amounts owed to regional alliances were collected and paid; and
- Assist regional alliances in establishing eligibility for subsidies of premiums and cost-sharing amounts and assume financial responsibility for errors that exceeded certain limits.

A designated state agency or official would be responsible for coordinating these activities at the state level.

States would also have substantial financial obligations. They would pay the regional alliances for their share of premiums for individuals and families who remained eligible for Medicaid, and they would be responsible for their share of Medicaid's spending on services not included in the standard benefit package for that group.

In addition, states would make maintenance-of-effort payments related to the restructured Medicaid program. Two components of these payments

would be on behalf of people who would lose their Medicaid coverage under the proposal. (Those people would no longer obtain coverage from the Medicaid program, but most of them would receive subsidies for their premiums for the standard benefit package.) One component would reflect 1993 expenditures for services in the standard package, and the other would reflect the part of states' payments to disproportionate share hospitals attributable to this group of people in that year. A third component would be based on fiscal year 1993 expenditures for children who remained eligible for Medicaid, excluding spending for services that would be in the standard package and for long-term care. The 1993 amounts would be updated by Medicaid-specific factors until the first year of a state's participation, and by the general health care inflation factor combined with the projected rate of growth in the population under age 65 thereafter.

Responsibilities of Regional Alliances. The regional alliances, by contrast, would not finance the health care system. Rather, they would serve as conduits of funds from the federal and state governments, employers, and families to health plans. They would be the frontline agencies that contracted with health plans, enrolled individuals and families in plans, and obtained and disseminated information on the performance of those plans. Regional alliances would also calculate the amounts that families and employers would have to pay, determine whether families and employers were eligible for subsidies, and collect payments from them. In addition, regional alliances would have to implement the cost control provisions required by the federal government. That would include establishing fee schedules for fee-for-service plans, unless the state elected to have a single, statewide fee schedule.

Regional alliances would also play an important role in collecting and analyzing data. They would, for example, have to estimate the number of workers in the different types of families; those numbers would be used in determining how much employers would have to pay. In addition, in order to determine the weighted average premium for each family type, each alliance would have to provide information to the National Health Board about the market shares of the different plans with which it had contracts.

All activities of the regional alliances would be paid for by an assessment on premiums. Each alliance would determine that level annually, but it could not exceed 2.5 percent of total premiums.

The Role of Employers and the Decision to Form a Corporate Alliance

Employers would have many of the same responsibilities whether they participated in a regional alliance or established a corporate alliance. In either case, employers would have to pay a portion of the premiums for their employees' policies. They would also have to deduct their employees' share of the premiums from their paychecks and transfer the funds to the appropriate alliance. In addition, all employers would have to provide specified information to their employees and to the regional alliances.

Most firms with 5,000 or fewer full-time employees would have to participate in regional alliances. (Some smaller firms might participate in multiemployer corporate alliances or ones established by rural electric and telephone cooperatives.) Larger firms, however, would have to decide whether to join a regional alliance or set up a corporate alliance after weighing the relative advantages and disadvantages of the two options. Firms would generally have to decide by January 1, 1996. A decision to participate in a regional alliance would be irrevocable; however, the decision to establish a corporate alliance could be reversed at a later date.

Advantages of Corporate Alliances. Large firms might choose to form a corporate alliance for several reasons. Firms that had already established effective programs for containing health care costs might think that they could control health spending better than the alliance system. Firms would also continue to have direct input into the quality of care their full-time employees received. In addition, they would not be responsible for the assessments that employers participating in regional alliances would

have to pay if there was a shortfall in premium payments. Finally, they would not have to pay the 1.5 percent assessment on premiums for graduate medical education and academic health centers that firms in regional alliances would pay. (Firms in multiemployer alliances would have to pay the 1.5 percent assessment, however.)

Disadvantages of Corporate Alliances. Despite the advantages of establishing a corporate alliance, significant disadvantages would predominate for many large firms. The most important one would generally be that firms that formed corporate alliances would have to pay a tax of 1 percent on their total payroll and that the tax would begin before the regional alliances were set up. (Firms participating in multiemployer alliances would not be subject to that tax.) Moreover, the effective rate of the tax on the payroll of full-time employees enrolled in plans offered by the corporate alliance would be higher than that, because the wages of part-time employees would be in the tax base but the employees would not be eligible to participate. (They would have to enroll in plans offered by the regional alliance, and the firms would have to make the appropriate payments to regional alliances on their behalf.)

Furthermore, a firm that established a corporate alliance would not be eligible for the cap on its premium payments that would be phased in if it joined a regional alliance. Moreover, its low-income employees who worked full time would not be eligible for governmental subsidies of their premiums, and the corporate alliance itself would generally have to subsidize premiums for full-time employees making less than $15,000 a year.[12] A firm that established a corporate alliance and chose to self-insure might also have to make periodic contributions (of up to 2 percent of annual premiums) to the insolvency fund established by the Secretary of Labor for self-insured health plans offered by corporate alliances.

Large firms that had self-insured in the past would probably experience considerably more regulation under the proposal. In addition to the federal requirements for health plans offered by corporate alliances that have already been discussed, the Secretary of Labor would specify financial reserve requirements that those alliances would have to meet. Their fee-for-service plans would have to use the same fee schedules as plans in their corresponding regional alliances. The growth rates of their premiums would be subject to essentially the same limits as those of the regional alliances. Finally, in addition to greater regulation, such firms might find themselves with relatively little power in markets dominated by large regional alliances.

Employers' Obligations for Retirees' Health Benefits. Regardless of whether they participated in corporate or regional alliances, all firms that were paying more than a specified threshold for retirees' health benefits on October 1, 1993, would continue to have obligations to those retirees and most of their dependents. When the subsidies for early retirees commenced in 1998, those employers would be required to pay 20 percent of the weighted average premium for the appropriate type of family. That obligation would continue only as long as members of that cohort remained eligible for the benefits of early retirees.

Because of the large financial windfall that firms with extensive obligations to retirees would gain under the proposal, all employers with health care costs for retirees aged 55 through 64 in 1991, 1992, or 1993 would also be subject to a temporary annual assessment. That assessment, which would be paid each year from 1998 to 2000, would equal one-half of either the average annual health care costs for retirees in the 1991-1993 period (increased by the medical care component of the CPI from 1992 on) or the estimated reduction in retirees' health care costs for the year--whichever was greater.

The Flow of Funds Through Regional Alliances and Health Plans

Regional alliances would receive funds from multiple sources, which they would then allocate to health plans and to other uses. The proposal specifies who would bear the financial responsibility in

12. No subsidy would be required if the employer's contribution covered at least 95 percent of the premium of the most economical plan that did not have higher cost sharing.

particular circumstances if outflows from alliances exceeded inflows.

Sources of Funds for Regional Alliances. Regional alliances would receive payments from the following sources:

- Payments (reflecting appropriate reductions because of subsidies) from employers;
- Payments (reflecting appropriate reductions because of subsidies) from families for the family share and, in some cases, for part or all of the equivalent of the employer share;
- Risk-adjustment payments from firms that were eligible to form corporate alliances but decided to join regional alliances;[13]
- Payments from corporate alliances for part-time employees and for employees in two-worker families who chose to participate in plans offered by regional alliances;
- States' payments for AFDC and SSI beneficiaries, who would make up the continuing Medicaid population;
- States' maintenance-of-effort payments, including those made on behalf of low-income people who would no longer be eligible for the restructured Medicaid program; and
- Federal payments for subsidies and for Medicare beneficiaries who were enrolled in plans offered by the regional alliances, as well as the federal share of Medicaid payments for AFDC and SSI beneficiaries.

Although Medicaid beneficiaries would be enrolling in plans offered by the alliances, Medicaid's payments to alliances on their behalf would not be related to the actual premiums of those plans. Rather, the payments would generally be 95 percent of what Medicaid would have paid in 1993 for the services in the standard benefit package, updated by Medicaid-specific inflation factors until the first year of the state's participation, and by the general health care inflation factor thereafter. (Those amounts would be estimated separately for the AFDC and SSI populations.)

Federal payments for subsidies would, in effect, be residual payments based on the difference between an alliance's payment obligations and amounts receivable from all other sources. As discussed below, however, the proposal specifies certain shortfalls between inflows and outflows that would not be considered federal responsibilities and would not be included in the calculation of those residual amounts.

Uses of the Regional Alliances' Funds. The funds of the regional alliances would be used primarily to make payments to health plans and to pay the alliances' administrative costs. Regional alliances would also pay the federal government 1.5 percent of total premiums in order to help the government finance academic health centers and graduate medical education. In addition, these alliances would make payments to corporate alliances for two-worker families who elected to enroll in a plan offered by the corporate alliance rather than in one offered by the regional alliance.

Health plans would not, however, receive their actual premium amounts. Instead, they would receive a per capita amount for each enrollee; that amount would be based on a weighted average of the final per capita premiums the plans had negotiated with the alliance and the amounts that Medicaid would pay for the AFDC and SSI populations. The weights would reflect the relative size of those populations in the alliance as a whole.

Regional alliances would also adjust the per capita amounts to reflect the risk status of each plan's enrollees. The risk adjustments would be designed to protect plans that enrolled people whose expected use of services was higher than that in the alliance as a whole. Risk adjustments could also be made for plans that enrolled disproportionate numbers of AFDC or SSI beneficiaries. Plans would, however, have to absorb part of the cost sharing

13. If people who would have been covered by plans offered by the corporate alliance were at greater risk than others covered by the regional alliance's plans, the firm would pay risk-adjusted premiums for the first four years. That adjustment would be phased out during the next four years.

they would generally require of participants, because Medicaid beneficiaries would pay only a small portion of it.

Allocation of Risk for Administrative and Estimating Errors. The payment obligations of regional alliances could exceed their receipts for a variety of reasons. Short-term problems with cash flow could result from administrative problems, disparities in the timing of receipts and payments, and estimating errors.

The federal government would not accept financial responsibility for cash flow problems arising from administrative errors that exceeded certain limits; such errors would occur primarily in determining eligibility for subsidies. Alliances could borrow from HHS for shortfalls resulting from such errors, but the states--not alliances--would have to repay the loans through increases in their maintenance-of-effort payments.

Regional alliances could also borrow from HHS for shortfalls arising from disparities in the timing of payments and receipts or from errors in estimates of the factors used to determine their inflows and outflows. These factors would include the number of extra workers in couples and two-parent families, the proportion of AFDC and SSI beneficiaries in the alliance, the distribution of families in different risk categories, the amount of premiums that would not be collected, and, under certain circumstances, the distribution of enrollment in plans with different levels of premiums. The loans would be repaid through reductions in future federal payments to the alliance.

In the first year of operation, however, no alliance could borrow more than 25 percent of its estimated total premiums from HHS. In subsequent years, an alliance's total outstanding loan amount could not exceed 25 percent of its premiums in the previous year. The Secretary of the Treasury would be authorized to advance funds to HHS to cover loans to regional alliances, but the total balance of advanced funds could not exceed $3.5 billion at any time. Regional alliances would also be able to borrow in the private credit markets, but they would be prohibited from using tax-exempt financing.

Controlling Health Care Costs and Limiting the Financial Exposure of the Federal Government

Besides ensuring universal coverage, the other major goal of the Administration's proposal is to control the rate of growth of health spending and, as a corollary, to limit the financial exposure of the federal government. The proposal employs a two-pronged approach to controlling costs: reliance on market forces and, as a backstop mechanism, federal control of the level and rate of growth of premiums. It also attempts to limit federal payments to alliances for subsidies.

Market Forces and Cost Containment

Competition among health plans in a regional alliance is one mechanism through which the proposal intends to control costs. Under the proposal, however, health plans would compete on a different basis than they do today. Those in a regional alliance would not be able to compete on the basis of the benefits they offered, as do current plans, because they would all be required to offer the same standard package of benefits, including standardized cost sharing, to all their enrollees. Moreover, supplementary policies to cover additional services would generally have to be available to any applicant, subject to capacity and financial constraints. Plans would therefore compete on the basis of the quality and convenience of their services and on the level of their premiums.

Families purchasing health coverage through a regional alliance would have incentives to select less expensive plans because the payments that employers would have to make would be independent of the plans their employees selected. In principle, families with workers who selected plans with premiums above the weighted average in the alliance would have to pay more than 20 percent of the premium, and those selecting plans with premiums below the weighted average would pay less than 20

percent. (That might not always be the case because of other adjustments, such as subsidies for low-income families, or because the employer paid more than the minimum required.) Families for whom no employer was paying premiums, including nonretiree families with no workers, would also have strong incentives to choose plans with lower premiums. They would have to make a trade-off, however, if the lowest-cost plans had higher cost sharing.

Box 1-2.
Controlling the Level and Growth of Premiums

The controls on premiums would be implemented differently in regional and corporate alliances. The National Health Board would establish the initial maximum per capita premium that would be permitted in each regional alliance; it would also set limits on its growth. In contrast, corporate alliances would experience controls only on the rate of growth of their premiums.

Setting Initial Premiums for Plans in Regional Alliances

The following steps describe the process for establishing and enforcing the initial level of premiums for regional alliances in states that chose to enter the system in 1996.[1]

The National Health Board would set a baseline target for the national per capita premium based on expenditures for the standard benefit package in 1993. These expenditures would, however, exclude spending for groups such as beneficiaries of Aid to Families with Dependent Children, Supplemental Security Income, and Medicare.

The target would also reflect expected increases in use of services by people who were uninsured or had coverage that was less comprehensive than the standard benefit package, declines in uncompensated care, anticipated reductions in use resulting from higher cost sharing, and cost-sharing amounts that would be required for services covered by the standard package. It would also include an allowance of up to 15 percent to cover the administrative costs of health plans and alliances and existing state taxes on premiums for health insurance. The board would inflate the 1993 national baseline target to 1995 using an inflation factor based on the rate of increase of health spending by the private sector but not more than 15 percent over the two-year period.

By the beginning of 1995, the board would adjust the 1995 national baseline target to establish a target for each regional alliance that would be operating in 1996. The adjustments would account for variations among alliances in health spending, insurance coverage, and spending by academic health centers. To obtain the 1996 targets, the baseline amount would be increased by each alliance's inflation factor. That factor would be the general health care inflation factor adjusted to reflect changes between 1995 and 1996 in the health status and demographic characteristics of each alliance relative to changes in the nation as a whole.

Health plans in a state that was planning to start participating in 1996 would then submit their bids for the per capita premium to each regional alliance in which they wished to operate. Each plan's bid would reflect its estimate of the average per capita premium for the standard benefit package in a particular alliance. Plans submitting bids would do so with the understanding that the board could, under circumstances described below, subsequently lower their bids, and they would have to accept any such reduction.

Following a negotiation period during which health plans might voluntarily lower their bids, each regional alliance would submit its final bids for the per capita premium from their health plans to the National Health Board for review. The board would use information from the alliance to estimate its weighted average bid; each plan's bid would be weighted by the expected enrollment in that plan. The result for each alliance would then be compared

1. A similar process would be followed for alliances that began in 1997 or 1998.

Comparison shopping by consumers would be easier because the regional alliances would provide information about factors such as the quality of care provided by each plan, and consumers would no longer be concerned about differences in benefit packages that were hard to detect. Annual open-enrollment periods would also facilitate moving out of plans that consumers found unsatisfactory.

with the target for that alliance's per capita premium.

If the weighted average bid exceeded the target for the alliance, the board would notify the alliance that it was not in compliance. It would also notify all plans whose bids were above the target that they would face compulsory reductions in their per capita premiums if they did not lower them voluntarily. The reductions would be a percentage of the amount that their bids exceeded the target and would be designed to lower the weighted average bid to the target. Plans with bids under the target would not be affected.

Any plan that chose not to lower its bid voluntarily would have its per capita premium--that is, the amount that would determine its funding from the alliance--reduced by the board. As a consequence, the plan would be required to lower its payments to providers. Those cuts in payments would reflect the proportional reduction in the plan's premium, adjusted for the anticipated increase in the volume of services that would result from the lower payments.

Limiting the Growth of Premiums

After its first year of participation, a regional alliance's target for the per capita premium would be the target for the previous year updated by that alliance's inflation factor. This inflation factor could differ in two ways from the definition used in the initial year. First, it would reflect any changes in the demographic characteristics of the regional alliance that occurred because a corporate alliance had terminated and its members had enrolled in the regional alliance. A second adjustment would occur if the actual per capita premium for the alliance exceeded its target in any year as a result of more people enrolling in high-cost plans than expected. In this case, the alliance's inflation factor would be reduced for the next two years so that health spending in the alliance would be reduced during the two-year period by enough to offset the higher expenditures made in the previous year.

After the initial year, changes would also be made in the procedure for determining the amounts by which bids for the per capita premium would be reduced for a regional alliance that did not comply with its target. To determine the extent to which a plan's bid was too high, the board would compare the current bid with the following amount: the previous year's bid plus the premium target for the current year, less either the premium target or the weighted average bid, if that was lower, for the previous year.[2] Bids submitted by new plans would be compared with the target for the alliance's per capita premium. The remainder of the procedure would be the same as in the initial year.

For corporate alliances, the cap on the rate of growth of premiums would be based on a comparison of the rate of growth of the three-year moving average of per capita spending with the rate of growth of the three-year moving average of the general health care inflation factor. In 2001, corporate alliances would have to start reporting their average per capita expenditures for the previous three years to the Secretary of Labor. If the rate of growth of the spending measure exceeded the rate of growth of the inflation measure in two years out of three, the alliance would be terminated and its members would enroll in plans offered by their regional alliances.

The board also would estimate targets for per capita premiums for single-payer states. If per capita spending for the standard benefit package in those states exceeded the targets, the states would be required to reduce payments to providers accordingly.

2. In the event that the plan's bid for the previous year had been reduced involuntarily, the amount of that reduction would also be subtracted.

Furthermore, limiting the exclusion of employer-paid insurance premiums from employees' income would heighten consumers' awareness of costs once the new system was fully phased in. Employer-paid premiums would be excluded until 2004, however, and then only employer-paid premiums for policies covering additional services would be included in employees' taxable income. Moreover, the proposal would substantially expand the income tax subsidy for premiums paid by the self-employed, further limiting the effectiveness of market forces in containing costs.

Controls on the Level and Rate of Growth of Premiums

To supplement the effects of market forces in containing health care costs, the proposal includes provisions for federal control of premiums for the standard benefit package. The principle underlying the proposed controls is that the national per capita premium for the standard benefit package should increase each year by no more than the general health care inflation factor. For the period from 1996 through 2000, the values of that factor would be the increase in the CPI plus specified amounts--1.5 percentage points in 1996, 1.0 percentage point in 1997, 0.5 percentage point in 1998, and zero in 1999 and 2000. After 2000, if the Congress did not specify new inflation factors, the default factor would be the percentage increase in the CPI combined with the percentage growth in real GDP per capita. (Adjustments would also be made in 2001 to account for at least a portion of the increase in the actuarial value of the benefit package that would occur in that year.)

How the controls would be implemented would differ somewhat in regional and corporate alliances. The National Health Board would establish both the initial maximum per capita premium that would be permitted in each regional alliance and the limits on its growth. Corporate alliances, however, would experience controls only on the rate of growth, not the initial level, of their premiums. Box 1-2 (on pages 22 and 23) describes the processes that would be used to set the targets for regional and corporate alliances, as well as the consequences of breaching the targets.

Limits on Federal Payments to Alliances

In a further attempt to limit the federal government's financial exposure, the proposal lists maximum total federal payments to alliances of the following amounts: $10.3 billion in fiscal year 1996, $28.3 billion in 1997, $75.6 billion in 1998, $78.9 billion in 1999, and $81.0 billion in 2000. After 2000, the limit would be the previous year's limit inflated by the increase in the CPI combined with the average annual percentage change in the population for the previous three years and the average annual increase in real GDP per capita for the previous three years.

The proposal also includes the procedures to be followed if federal payments to alliances were expected to exceed the limits. In particular, the President would have to recommend to the Congress policies to resolve the conflict. The proposal also states that these recommendations would be considered in an expedited manner and would not be subjected to the routine procedural hurdles that tend to slow Congressional consideration of legislation. Because the Congress has the constitutional right to make and change its own rules, however, procedural mechanisms cannot guarantee that an issue will be considered. If the Congress took no action, the courts might be asked to decide which portion of the legislation took precedence--payments to the alliances to ensure coverage of the specified benefits or the limits on federal payments.